Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS INTERPRETING SERVICE
PO BOX 26045
FRESNO CALIFORNIA 93729

Respondent Name
ROCHDALE INSURANCE CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-06-0543-01

MFDR Date Received
September 14, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Spanish-speaking patient was provided with interpreter services as a special accommodations as indicated in Rule 140.1. The language barrier makes it a necessity for the patient to be assisted by an interpreter in order to be able to communicate with his or her physician. Said services have been provided at North Texas Rehabilitation Center who promotes recovery as stated in Section 408.021. The physician, whose name, credentials and license number appears in box 31 & box 33, provided treatment. Said treatment required the use of an interpreter. Per Q&R dated 8/1/1996, 99199 is the correct code to use when billing for interpreter services; a specific CPT code is not available."

Amount in Dispute: $1,020.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has given dates, but no written documentation of the service provided. The service has an unlisted CPT code, and the provider has not shown this is a fair and reasonable amount for this service. The requestor has only 2 dates of service with a written request for this service, 4/30/05 and 4/29/05. Please note that no provider has billed office visits for these dates – the patient was in a work hardening program and no other services, as 'follow-up visit' have been billed to the carrier. The patient did not have, not [sic] was he approved, to received [sic] psychological care. The providers of the work hardening program have no information in their notes that an interpreter was needed or used for any of the dates billed. The requestor has not provided the burden of proof that these services were provided as billed."

Response Submitted by: Amtrust North American, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 200 through May 21, 2005	Interpreting Services	$1,020.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on September 14, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 20, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
3. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
4. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 6, 2005
   - W1 (YO) – RC YO Denial after reconsideration
   - W1 (YU) – Workers Compensation State Fee Schedule Adjustment

Issues

1. Did the requestor submit documentation to support that the services billed were rendered?
2. Did the requestor submit documentation to support fair and reasonable reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 TAC §133.307 (g)(3)(B) "(3) If the request contains only medical fee disputes, the commission shall notify the parties and require the requestor to send to the commission, two copies of additional documentation relevant to the fee dispute. The additional documentation shall include: (B) a copy of any pertinent medical records or other documents relevant to the fee dispute..." Review of the documentation finds:
   - The requestor did not submit a copy of pertinent medical documentation related to the disputed services.
2. Per 28 TAC §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." Review of the documentation finds:
   - The Division finds that CPT code 99199 does not have a Medicare fee schedule assigned.
3. Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers" Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor did not submit documentation to support that $1,020.00 was a fair and reasonable rate of reimbursement for CPT code 99199.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
6. The request for reimbursement for CPT code 99199 is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended for CPT code 99199.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.